PRINTED: 04/10/2009 FORM APPROVED

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED				
NVS4352HIC				D: 11110		12/26/2008			
NAME OF PROVIDER OR SUPPLIER GOLDEN RETREAT CARE HOME			3730 LEISU	EET ADDRESS, CITY, STATE, ZIP CODE 10 LEISURE LANE 15 VEGAS, NV 89103					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE		
H 000	H 000 Initial Comment			H 000					
	This Statement of Deficiencies was generated as a result of a State Licensure survey and complaint investigation initiated in your facility on 8/26/08 and completed on 12/26/08. This State Licensure survey was conducted by authority of NAC 449, Homes for Individual Residential Care, adopted by the State Board of Health on November 29, 1999.								
		6888 was substantiated were cited as a result							
H 014	Director Duties-Dignity, Respect; Not Abused		d	H 014					
	The director of a hom 3. Ensure that the res	sidents of the home: lignity and respect and	·						
	Based on interview a 8/26/08 to 12/26/08, to	ot met as evidenced by nd record review from the director failed to en e facility was protected	sure						
	Findings include:								
	1/01/05 with diagnose	nitted to the facility on es including mental etes mellitus. There was	s no						

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS4352HIC 12/26/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3730 LEISURE LANE GOLDEN RETREAT CARE HOME** LAS VEGAS, NV 89103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 014 H 014 Continued From page 1 evidence of the date of discharge in the resident ' s record. A driver of a bus that picks up Resident #3 at the facility reported witnessing the resident being abused by caregivers. On 11/02/07, the Bureau investigated the complaint at the facility. During interviews, the resident denied she was being abused and caregivers denied abusing the resident. The facility was licensed to care for two residents and the owner, Employee #2, admitted she had two other residents in addition to Resident #3. On 11/29/07, the complaint was not substantiated but the owner was cited for being over census. A second complaint from the bus driver was received on 12/20/07. The bus driver provided a written statement about witnessing another occurrence of abusive treatment of Resident #3 by caregivers on 12/17/07. On 8/26/08, a caregiver, Employee #1, and the owner of the facility were interviewed. They both reported Resident #3 no longer lived at the facility. The caregiver stated Resident #3 was just renting room at the facility and she had no problems with the resident. The owner stated Resident #3 had been a "boarder" at the facility for the last 10 years and needed only minimal assistance from the staff. During the 11/2/07 investigation, the owner admitted Resident #3 was a resident at her facility and not a boarder. There were no documented reports of incidents or injuries in Resident #3's record and the owner denied hearing of any problems between her staff and the resident.

In a telephone interview on 8/26/08, a caregiver, Employee #4, stated Resident #3 needed "a lot of

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Based on statements from the witness of the

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NVS4352HIC				B. WING		12/26/2008				
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE					
GOLDEN RETREAT CARE HOME				3730 LEISURE LANE LAS VEGAS, NV 89103						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMA			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETE DATE			
H 014	Continued From page 3			H 014						
	incidents of physical abuse of Resident #3, the resident's statements and the guardian's statements, the owner of the facility failed to prevent the abusive treatment of Resident #3 by facility employees.									
H 019	Director Duties-Qualified Caregiver			H 019						
	NAC 449.15523 Director: Duties. (NRS 449.24 The director of a home shall: 4. Ensure that a caregiver, who is capable of meeting the needs of the residents and has be trained in first aid, and cardiopulmonary resuscitation, is on the premises of the home a all times when a resident is present. This Regulation is not met as evidenced by: Based on record review and staff interview on 8/26/08, the director did not ensure that 2 of 3 caregivers had received training in cardiopulmonary resuscitation (CPR) and first aid. Findings include:		f been							
			on 3							
		s #2 and #3 did not cor ees had been trained in								
H 030	Safety & Sanitation-Home Clean; Hazard Free		ee	H 030						
	sanitation of facility. (uirements for safety and NRS 449.249) terior of a home must b ards and offensive odo	pe							
	This Regulation is not met as evidenced by:									

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